Special Report
State of Iowa

Citizens' Aide/Ombudsman
Report of Task Force into Critical Incidents within the Iowa Prison System

TO: Honorable Thomas J. Vilsack
Governor

Report # 04 - 02
Issued: August 2, 2004

Introduction

Governor Tom Vilsack, concerned about the deaths of two Iowa inmates at the Anamosa State Penitentiary (ASP), asked the Citizens' Aide/Ombudsman (Ombudsman) to review the incidents and provide an assessment of each incident. The Governor also asked the Ombudsman to propose a set of recommendations for improving inmate and staff safety within ASP.

The Ombudsman met with the Director of the Iowa Department of Corrections (DOC) who pledged his agency's cooperation. As a result of that meeting and review of investigations by the Division of Criminal Investigations (DCI), Department of Corrections' inmate files, and autopsy reports, the Ombudsman proposed a Task Force to conduct the review.

The Ombudsman suggested working with the Iowa Protection and Advocacy and the Iowa State Medical Examiners Office due to their expertise in areas discussed in this report.

This Task Force is comprised of the following agencies and designated staff:

Iowa Citizens' Aide/Ombudsman Office

William P. Angrick II, Ombudsman
Ruth Cooperrider, Deputy Ombudsman/Legal Counsel
Judith Milosevich, Assistant Ombudsman for Corrections
Kyle White, Assistant Ombudsman

Iowa Department of Corrections

Gary D. Maynard, Director
Harbans Deol D.O., Ph.D, Medical Director
Fred Scaletta, Public/Media Relations Officer
Michael Savala, Legal Counsel

Iowa Medical Examiner's Office

Julia Goodin M.D., State Medical Examiner
John Kraemer, Director Forensic Operations

Iowa Protection & Advocacy, Inc.

Sylvia Piper, Director
David Parr, Advocacy Coordinator
Nancy Simon, Disability Rights Advocate/Investigator

At its inception, the goal of this Task Force was to establish the facts of each incident, analyze compliance with policy and procedure, and if necessary, recommend change. After the Ombudsman selected the core members of the Task Force, the 2003 death of another inmate at the Iowa State Penitentiary (ISP) prompted an additional request by Governor Vilsack to include the events surrounding his death in the Task Force's review. Independently, the Ombudsman included in his review an offender who displayed several self-mutilative acts while incarcerated at the Iowa Correctional Institution for Women (ICIW).

In the initial review, the Ombudsman discovered one common thread: mental illness. All four individuals [redacted] and each was placed in to a heightened observation status during their incarceration. One committed suicide, one injured himself with staff intervention probably leading to his death, one was able to severely mutilate herself, and one died from unknown causes.

Redactions in Report

Iowa Code section 2C.9 allows the Ombudsman to have access to information relevant to an investigation. The Ombudsman, however, is prohibited from disclosing information that is confidential by law. The Ombudsman consulted with the appropriate agency officials or their attorneys regarding what information can be disclosed in the report, based on applicable statutes and rules. As a result of consultation, the Ombudsman has agreed to redact those parts of the report the officials or their attorneys believe to be confidential by law. The legal authority for each redaction is provided in the endnotes on pages 67 - 70 of the report.

Recommendations

The Task Force believes increased training is the most important element.

With that in mind, the Task Force believes DOC should:

- Seek accreditation for the Iowa Department of Corrections training academy. The Task Force believes the ultimate goal should be certification of correctional officers in a manner similar to certification for police officers and jail personnel.

- Increase amount and types of training for correctional officers. Security officers who deal daily with mentally ill offenders need the most immediate and extensive training. The Task Force believes DOC needs to conduct annual training of all officers in identifying offenders in crisis. Training must include more information about de-escalation techniques. Ensure all staff receives annual training in the Use of Force continuum. Consider other restraints and devices to obtain control if de-escalation is not successful. Invite Iowa Protection and Advocacy, Inc and other knowledgeable groups or persons to review training curriculum.

- Include medical and security staff at the same training because each needs to understand the importance of the others' role.

- Include in the pre-service and in-service training all officers practicing videotaping other officers in mock cell entries. This should also be practiced on an annual basis with DOC providing examples of improper or delayed responses and inadequate video quality for officers to understand the importance of these exercises.

- Ensure all institutions provide appropriate protective gear. As part of the pre-service training and annual training, staff should be required to practice donning and doffing this clothing and gear and when it is appropriately used.

- Develop a training module on scene preservation and scene investigation to ensure critical evidence is not lost or compromised.

Mental Health Services

DOC should:

- Provide for emergency psychiatric and psychological intervention to be available at all times at all DOC institutions. One option is to hire sufficient psychiatrists to provide for 24-hour coverage. Another option may be to coordinate with the Iowa

Department of Human Services to share psychiatric and psychological services from the state mental health institutions.

- Purchase portable telemedicine terminals to facilitate observation of offenders by a psychiatrist or psychologist.

- When appropriate, utilize its statutory authority, in conjunction with the Department of Human Services, to transfer an offender to a mental health institution while retaining jurisdiction.

- Expand the companion inmate policy to all institutions.

Offender Deaths/Critical Incidents

DOC should:

- Explore legislation to create a Critical Incident Task Force modeled after Iowa Fatality Review Committee, to review offender deaths (other than by known natural causes) and critical self-injurious situations.

- Hire an inspector general at DOC to supervise, coordinate, and direct the efforts of all investigators at the institutions.

- Develop a centralized repository for reports of deaths of offenders in prisons, community-based corrections, and jails. Judicial districts and jails should be required to report the deaths of all offenders while under their supervision.

The State Medical Examiner should:

- Amend the Iowa Administrative Code, 641 – chapter 127, to require autopsies on all deaths in a prison, jail or other correctional facility, or under the custody of a law enforcement agency, except those where a natural disease process clearly caused the individual's death. [Current rule 641.1273(2)(c) recommends that a county medical examiner performs autopsies in the following cases: "Deaths in a prison, jail, or correctional institutions, or under police custody, where there is not a natural disease process which accounts for the death."]

- Amend Iowa Administrative Code, 641 – chapter 127, to require that all such in-custody deaths be sent to the State Medical Examiner's Office and the autopsies by performed by a forensic pathologist.

- Ensure County Medical Examiners and their Investigators are aware of the above changes in the Iowa Administrative Rules.

- Add specific guidelines to the County Medical Examiner Handbook that address in-custody death investigations. (Refer to Appendix C for these guidelines.)

- Ensure all toxicology and other laboratory testing be performed at a forensic laboratory.

[NOTE: The Task Force points out that sufficient funding is necessary to enable the State Medical Examiner to assume these additional responsibilities.]

Department of Corrections Response

In response to these incidents, the Iowa Department of Corrections provided the Task Force with the following information regarding the changes they have pro-actively made:

- Revised the mental health training for new employees and recommended a refresher course for all employees yearly.
- Training video for cell entry completed. Training recommended for all security staff at all prisons.
- Revised policy on Suicide/Self-Injury Prevention and restraints.
- Revising the DOC Mental Health Observation policy.
- Developed an inmate companion policy patterned after Bureau of Prison.
- Modified the Use of Force policy to prohibit use of prone restraint.
- DOC requests death investigations be done according to guidelines provided by the State Medical Examiners Office.
- Monitoring of equipment check at a regular interval (i.e. video, battery, crash carts, etc.).
- Training in gowning and cell entry in a timely fashion.
- Implemented timely and consistent Critical Incident Reporting Policy for both institutions and Judicial Districts.
- Revised policies to ensure review and approval of all new and modified policies by Regional Deputy Directors.
- Purchased three portable telemedicine machines to be utilized at the Clarinda Correctional Facility, Iowa Medical and Classification Center, and the Clinical Care Unit located at the Iowa State Penitentiary.
- Added an additional 16-bed unit at ICIW within Unit Six for female special needs structured living.
- Revising DOC policy AD-I-11 to require in cases of imminent death of an offender, the Warden will notify the DOC Director of any death that is not the result of natural causes where DCI will be called to investigate. The DOC Director will coordinate investigations with DCI.

- DOC Director will contact DCI about amending DCI Directive C.200, non-criminal investigations, for DCI to contact the DOC Director after arriving at a correctional facility to conduct an investigation. Current practice requires DCI to notify a warden.

Attached is the list of specific recommendations of Iowa Protection and Advocacy, Inc. The Task Force believes the spirit of most of these was incorporated into the Task Force Recommendations. They are listed in their entirety.

Iowa Protections and Advocacy Recommendations

- Continue active Task Force meetings to proactively focus on prevention, possibly quarterly meetings. Invite DHS, legislators and DCI possibly again.

- Suggested training resources: MANDT System, BRACEanalysis.com (Russell Smith) and JIREH Consulting and Training (800-656-3044 ext. 62)[76]

- Inmate Companion Policy: screening and training is crucial. We do not want to set up a vulnerable inmate to be manipulated and/or abused by these companions.

- Implement into the revised DOC Mental Health Observation policy irregular visual checks. This way the inmate will not be able to plan anything in-between checks as they will be random, such as in the Madigan case.

- Ensure heightened awareness when reintroducing items to the inmate when on "suicide watch."

- Possible use of a padded room, helmet and/or PRN med. in cases such as Mundy.

- Ensure appropriate medication follows the inmate. This could be crucial to their treatment.

- Ensure Emergency Services are available to perform post traumatic incident follow-up with both staff and inmates involved.

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[76] The Ombudsman performed additional research on these referenced systems. According to <www.mandtsystem.com>, "The Mandt System® teaches the use of a graded system of alternatives which uses the least amount of external management necessary in all situations. The entire philosophy of The Mandt System® is based on the principle that all people have the right to be treated with dignity and respect." JIREH provides training in crisis prevention, crisis intervention and de-escalation, "safe least restrictive control techniques", and restoration counseling. <www.jirehtraining.com>. According to <www.braceanalysis.com>, BRACE™ "is an acronym for Behavioral Relativity and Cognitive Economics. BRACE Analysis, Inc. is more concerned with education than therapy, focusing on helping others to better understand human nature in order to avoid many of life's pitfalls and to create adaptive change on purpose." (June 24, 2004)

- Stun gun: do not use in the spinal area and use judgment when the inmate is already in a state of delirium and obviously immune to pain @ that time.

- Mace: provide decontamination for all involved parties after use of mace.

- Ensure audio is clear during taping. This could be vital in an incident.

- If the MHI's do not accept a transfer, could the mental health staff from these institutions be utilized to enhance the mental health system in the prisons throughout Iowa.

- Recommend this task force backs the following legislative piece: Mentally Ill Offender and Crime Reduction Act of 2003.

- Suggest that Iowa consider a project such as the "Nathaniel Project."[77] This is an alternative treatment program as an option to incarceration.

- P&A recommended the use of a Self-Injury Risk Indicators Card and the DOC has implemented this recommendation by laminating 5000 cards that the Correctional Officers can carry in their wallets. P&A applauds this.

- Applaud the DOC for modifying the Use of Force policy to prohibit use of prone restraint.

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According to the Ombudsman's research, "The Nathaniel Project is an alternative to incarceration program for people with serious mental illness who have committed felony offenses. This program is a two-year alternative to incarceration for people who have been indicted on a felony offenses, who are facing prison terms of generally three to six years, and have a serious mental illness. Most of the mental health courts that have developed in recent years were designed to provide services for misdemeanant offenders. The Nathaniel Project recognized the need to address needs of the felony offender with serious mental health issues.

No one is rejected from this program based on the severity of the offense or history of-violence. Project staff closely evaluates each case and individuals who pose a real public safety risk are screened out. Once accepted Project staff advocate for the individual with the Judge, prosecutor, and defense counsel, educate them about client's psychiatric needs; and persuade the stakeholders releasing the client to the Project would result in a better outcome for the client and the community than sending the person to prison.

The goal for each client is to be connected with housing and mental health services that they will continue to participate in without court supervision." National GAINS Center for People with Co-Occurring Disorders in the Justice System (2002). *The Nathaniel Project: An Alternative to Incarceration Program for People with Serious Mental Illness Who Have Committed Felony Offenses,* Program Brief Series, Delmar, NY: The National GAINS Center.